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IMPLICATIONS OF TOM BEAUCHAMP AND JAMES CHILDRESS MEDICAL ETHICS ON THE ATTITUDES OF THE MIDWIVES IN PUBLIC HOSPITALS IN NIGERIA

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Abstract

Tom L. Beauchamp and James F. Childress were ethical theorists. They set out what they considered the four basic principles of Biomedical Ethics for the improvement of healthcare services among health workers. According to these philosophers the basic principle of biomedical ethics include; autonomy, nonmaleficence, beneficence, and justice. They indicated that these principles are the cornerstones of ethical decision-making in healthcare delivery and underscore human rights, particularly with respect to patient care. However, in Nigeria, the practical application of these principles in labour wards among midwives have become a herculean tax. Midwives face ethical dilemmas in their clinical practice, where their decisions significantly affect the well-being of mothers and infants. This is rooted in the systemic, cultural, and professional factors. These challenges often lead to a divergence between theoretical ethical standards and clinical reality, characterized by resource scarcity, hierarchical power structures, and a preference for paternalistic care.

Keywords: Beauchamp, Childress, attitudes, midwives, and public hospitals.

Introduction

A midwife is a trained healthcare professional who provides comprehensive, personalized care to women during pregnancy, labour, delivery, and the postpartum period, as well as gynaecological and reproductive health services. The world Health Organisation stated that, a midwife is a qualified professional who has successfully completed a recognized education program necessary/required for providing essential care, support, and advice during pregnancy, labour, and the postpartum period, while conducting deliveries on their own responsibility[1]. Midwives specialize in promoting normal birth, providing education, and supporting pregnant women with a focus on low-intervention care. Midwives have strong public health functions, such as teaching mothers on the need for ensuring access to clean water and sanitation during childbirth, supporting breastfeeding mothers, delivering family planning services and tobacco cessation in pregnancy[2]. In an ideal society, midwives operate in homes, hospitals, and clinics to reduce child morbidity, maternal mortality and ensure safe, respectful care. In the practice of safe delivery, the midwife is expected to be courteous and

[1] World Health Organisation, Midwife. https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/maternal-health/midwifery 2026

[2] Ahmed A, Ali HS, Mahmoud MA. Prioritizing Well-being of Patients through Consideration of Ethical Principles in Healthcare Settings: Concepts and Practices. Systematic Reviews in Pharmacy. 2020; 11: 643-648.

attend to client needs immediately when taking delivery. Rhodes .revealed that the midwives' approach to pregnant women had positive influence on women's experience of labour pain[3]. Labour is the expulsion of the foetus, placenta, and membranes through the birth canal. Zuarez-Easton et al. defined labour as the process during which the pregnant uterus empties its content at about 40 weeks of pregnancy (labour may start two weeks before or two weeks after 40 weeks). Labour is a very stressful life experience of women, and so the attitude of midwives during labour will either affect them positively or negatively. The emotions of the women in labour greatly influence their reactions to discomfort and pains and are contributing factors in determining the amount of physical and mental exhaustion the woman will experience; hence, the whole process of childbearing should be handled with sensitivity and compassion[5]. This can only be actualised through strict adherence of principles of medical ethics enunciated by Tom Beauchamp and James Childress medical ethics.

Tom Beauchamp and James Childress are American philosophers and influential figures in bioethics, best known for establishing "principlism" in their 1979 seminal textbook titled *Principles of Biomedical Ethics*. Tom L. Beauchamp and James F. Childress set out what they considered the four basic principles of Biomedical Ethics[4]. These according to them are autonomy, nonmaleficence, beneficence, and justice. These according to Tom Beauchamp and James Childress ought to be the cornerstones of ethical decision-making among healthcare service practitioners. All these four principles according to Beauchamp and Childress underscore human rights, particularly with respect to patient care (women in labour in the context of the study).

Beauchamp and Childress' first principle of biomedical ethics is autonomy. Autonomy in medical ethics is the fundamental right of competent patients to self-determination, allowing them to make informed, voluntary decisions about their own healthcare based on personal values. Autonomy requires full disclosure from practitioners and forms the basis for informed consent, confidentiality, and shared decision-making. Autonomy according to Beauchamp and Childress emphasizes on self-rule (autos "self" and nomos ("rule") "free from both controlling interference by others and from certain limitations such as inadequate understanding that prevents meaningful choice." [5]In their view, most theories of autonomy such as *liberty* (the independence from controlling influences) and *agency* (the capacity for intentional action) as the two essential conditions[6]. Autonomy in medical ethics is the fundamental right of competent patients to self-determination, allowing them to make informed, voluntary decisions about their own healthcare based on personal values. It

[3] Rhodes R. The trusted doctor: Medical ethics and professionalism, Oxford University Press. 2020.

[4] Testa M, Cappuccio A, Latella M, Napolitano S, Milli M, Volpe M, et al. The emotional and social burden of heart failure: integrating physicians', patients', and caregivers' perspectives through narrative medicine. BMC cardiovascular disorders. 2020; 20: 522.

[5] (Beauchamp and Childress . Principles of biomedical ethics, Oxford University Press, USA. 2001.2009, 99)

[6] *Ibid* 2009, 100)

requires full disclosure from practitioners and forms the basis for informed consent, confidentiality, and shared decision-making. Respect for autonomy is not a mere *ideal* in health care; it is a professional *obligation.* Autonomous choice is a *right,* not a *duty* of health professionals," Beauchamp and Childress noted that even prisoners, terrorists, have a right to their medical records.

The second principles of Beauchamp and Childress is nonmaleficence. Non-maleficence in medical ethics is the obligation to "do no harm" (*primum non nocere*), requiring healthcare providers to avoid causing unnecessary pain, suffering, or injury to patients. It is one of the four key principles of healthcare ethics, often balanced against beneficence (doing good) by weighing treatment risks against potential benefits. The duty of nonmaleficence is in accordance with the Hippocratic Oath maxim "Do no harm." That sets a minimal standard of behavior: 'Whatever you do for your patients, at least do not harm them'. The duty of beneficence (Principle 3) sets a higher standard by calling on medical personnel to maximize benefits for their patient and prioritize their well-being. Nonmaleficence and beneficence are companion principles, Beauchamp and Childress noted that, if possible, help others, do what you can to make an affirmative difference and address personal needs. If you cannot reach that standard, minimally do not harm them'. Beauchamp and Childress pointed out some specific rules that draw on the Principle of Nonmaleficence to include; do not kill; Do not cause pain or suffering; Do not incapacitate; Do not cause offense and do no deprive others of the goods of lif[7]e.

Thirdly the principle of beneficence. Beneficence is the ethical duty of physicians to act in the patient's best interest. According to Beauchamp and Childress, the principle of beneficence is the obligation of physician to act for the benefit of the patient and supports a number of moral rules to protect and defend the right of others, prevent harm, remove conditions that will cause harm, help persons with disabilities, and rescue persons in danger. It is worth emphasizing that, in distinction to nonmaleficence, the language here is one of positive requirements. The principle calls for not just avoiding harm, but also to benefit patients and to promote their welfare. Unlike nonmaleficence, which requires the physician to avoid actions that are harmful to a patient, the principle of beneficence creates an affirmative obligation for the physician to act in the patient's best interest[8].

Finally, the principle of justice. The principle of justice in medical ethics mandates fairness, equity, and impartiality in the distribution of health resources, treatment, and care. It requires that similar cases be treated similarly, ensuring equal access regardless of social standing, diagnosis or demographic characteristics and focuses on balancing individual needs with societal resources. According to Beauchamp and Childress, justice is generally interpreted as fair, equitable, and appropriate treatment of persons. Of the several categories of justice, the one that is most pertinent to clinical ethics is *distributive justice*. Distributive justice refers to the fair, equitable, and appropriate distribution of health-care resources determined by justified norms that structure the terms of social cooperation. Based on this, one might ask, how can this be accomplished? There are different valid principles of distributive justice. These are distribution to each person (i) an equal share, (ii) according to need, (iii) according

[7] *Ibid* 56

[8] Bester JC. Beneficence, interests, and wellbeing in medicine: what it means to provide benefit to patients. The American journal of bioethics. 2020; 20: 53-62.

to effort, (iv) according to contribution, (v) according to merit, and (vi) according to free-market exchanges. Each principle is not exclusive, and can be, and are often combined in application[9]. It is easy to see the difficulty in choosing, balancing, and refining these principles to form a coherent and workable solution to distribute medical resources[10].

From the foregoing, strict application and adherence of these principles by the midwives in various healthcare facilities would lead to an egalitarian healthcare service that would promote healthcare for mothers and their neonates. However, in various health facilities in Nigeria, it appears that the reverse is the case. According to Ebeh, in various hospitals in Nigeria, the midwives act as demigods. The rights of women in pregnant labour are not respected, as every decision is made by the midwives with little or no consent of the patient relatives. Again, the principle of beneficence and justice are frequently violated as adequate health care services is giving to the highest bidder. In line with this, Ocham indicated that in many contexts, particularly resource-constrained public hospitals, these principles are often violated due to institutional, cultural, and professional pressures. This could be the reason most elites in the country usually engage in medical tourism overseas where their rights and values are respected as proposed by Beauchamp and Childress. It is based on this that the paper examines implications of Tom Beauchamp and James Childress medical ethics on the attitudes of the midwives towards women in labour in public Hospitals in Nigeria.

Roles of Midwives in healthcare Facilities

All those working in maternity care have shared aims; to support health, wellbeing and a positive experience of care around pregnancy, birth and the early weeks of life; to consider long term as well as short term effects of care; to give the best start in life and family integrity; and to contribute to the growth of secure attachments between parent(s) and baby. These aims also include; the reduction of mortality and morbidity of mother and baby during pregnancy, birth and postpartum, including the morbidity of unnecessary intervention. Midwives are at the epicentre of maternity care service in the healthcare facilities. Midwives are skilled health professionals responsible for providing comprehensive care to women during pregnancy, labor, and the postpartum period, while supporting newborn health. Their key responsibilities include managing low-risk pregnancies, conducting normal vaginal deliveries, providing prenatal education, performing postpartum exams, and detecting complications requiring medical intervention.

Core Roles and Responsibilities of Midwives in maternity care services include

- **Prenatal Care:** Prenatal care is essential preventive health care for pregnant individuals. This care focuses on regular check-ups, screenings and lifestyle advice to ensure a healthy pregnancy and baby. Midwives in the maternity care facilities help to manage conditions like high blood pressure and diabetes, reduces risks of preterm

[9]Basil Varkey. Principles of Clinical Ethics and Their Application to Practice. *Med Princ Pract* (2021) 30 (1): 17–28.

[10] Beauchamp TL, Childress JF. Principles of biomedical ethics, Oxford University Press, USA. 2001:79).

birth or low birth weight, and usually begins before pregnancy or as soon as a woman knows she is pregnant. Monitoring the physical and emotional health of the pregnant person, offering advice, and conducting prenatal education[11].

- **Intrapartum Care (Labor and Birth):** Managing normal vaginal births, supporting women with mobility, using non-pharmacological pain relief methods (e.g., warm compresses), and facilitating a positive birth experience.
- **Labor and Delivery:** Labor and delivery is the process of childbirth, comprising three main stages: cervical dilation (contractions and thinning), birth of the baby (pushing), and delivery of the placenta. Lasting hours to days, it involves monitoring "power" (contractions), "passage" (pelvis), and "passenger" (baby). Key signs include regular, intensifying contractions and bloody show. Facilitating physiological childbirth, providing pain management support, and conducting deliveries in hospitals, clinics, or home settings. It is the role and responsibilities of the midwives to monitor pregnant women during labour and delivery
- **Newborn Care:** Newborn care refers to the art and act of keeping the baby warm, feed, clean and keeping safe during the first few weeks of life. Key practices include frequent breastfeeding (8–12 times/day), umbilical cord care (keeping it dry), safe sleep on their back, and skin-to-skin contact. Key safety rules include washing hands, supporting the head/neck, and never shaking the baby. Assessing the newborn immediately after birth, conducting initial exams, and assisting with immediate postnatal care. It is the duty of and responsibilities of the midwives to take care of the newborns and as well educate mothers on the best newborn care practices[12].
- **Postpartum Support:** Postpartum support includes emotional, practical, and medical resources for new parents, focusing on recovery and mental health. It is the function of the midwives to provide care for up to six weeks after birth, including supporting breastfeeding and checking on maternal recovery.
- **Detection of Complications:** Identifying complications in mother or child and referring to specialized medical care.
- **Women's Health Care:** Providing family planning counseling and, in some contexts, gynecological services (e.g., Pap smears).
- **Empowerment and Education:** Providing culturally sensitive, evidence-based care to empower women to make informed decisions about their birth experience.

Midwives work in partnership with women and play a crucial role in reducing maternal and neonatal mortality by ensuring access to essential care.. They manage low-risk births, conduct prenatal checkups, assist in postpartum care, and detect complications for early referral. Midwives also provide family planning, education, and support to families, playing a vital role in reducing maternal and neonatal mortality.

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[11] World health Organisation, Midwifery. www.wh/midwifery.com

[12] Veatch RM (1995). Resolving conflicts among principles: ranking, balancing, and specifying. Kennedy Inst Ethics J.;5:199–218

Tom Beauchamp and James Childress' biomedical ethics principles

Tom Beauchamp and James Childress' biomedical ethics principles can be grouped under four general categories: (*1*) respect for autonomy (a principle requiring respect for the decision-making capacities of autonomous persons), (*2*) nonmaleficence (a principle requiring not causing harm to others), (*3*) beneficence (a group of principles requiring that we prevent harm, provide benefits, and balance benefits against risks and costs), and (*4*) justice (a group of principles requiring appropriate distribution of benefits, risks, and costs fairly). I will concentrate on an explication of each of the principles and how they are to be understood collectively as a framework.

Respect for Autonomy

Respect for autonomy is a fundamental ethical principle requiring that individuals be permitted to make their own, self-directed decisions without external control or manipulation. It respects a person's capacity for rational thought, self-governance, and freedom, particularly through informed consent in clinical settings. Respect for autonomy is rooted in liberal moral and political traditions of the importance of individual freedom and choice. In moral philosophy, personal autonomy refers to personal self-governance: personal rule of the self by adequate understanding while remaining free from controlling interferences by others and from personal limitations that prevent choice. *Autonomy* means freedom from external constraint and the presence of critical mental capacities such as understanding, intending, and voluntary decision making[13]. The autonomous individual acts freely in accordance with a self-chosen plan, analogous to the way an independent government manages its territories and sets its policies. A person of diminished autonomy, by contrast, is in some respect controlled by others or incapable of deliberating or acting on the basis of his or her desires and plans[14].

To respect an autonomous agent is to recognize with due appreciation that person's capacities and perspectives, including his or her right to hold certain views, to make certain choices, and to take certain actions based on personal values and beliefs. The moral demand that we respect the autonomy of persons can be expressed as a *principle* of respect for autonomy that states both a negative obligation and a positive obligation. As a negative obligation, autonomous actions should not be subjected to controlling constraints by others. As a positive obligation, this principle requires respectful treatment in informational exchanges and in other actions that foster autonomous decision making.

Many autonomous actions could not occur without others' material cooperation in making options available. Respect for autonomy obligates professionals in health care and research involving human subjects to disclose information, to probe for and ensure understanding and

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[13] Buchanan, DR Autonomy, Paternalism ,and Justice: Ethical Priorities in Public Health. American Journal of Public Health. 2008.98)1): 15 – 21

[14] Beauchamp, TL & Childress, JF (1994). Principles of biomedical ethics. 4th edition. Oxford University Press. 2008. p 113

voluntariness, and to foster adequate decision making. True respect requires more than mere noninterference in others' personal affairs. It includes, at least in some contexts, building up or maintaining others' capacities for autonomous choice while helping to allay fears and other conditions that destroy or disrupt their autonomous actions. Respect, on this account, involves acknowledging the value and decision-making rights of persons and enabling them to act autonomously, whereas disrespect for autonomy involves attitudes and actions that ignore, insult, demean, or are inattentive to others' rights of autonomy.

Many issues in professional ethics concern failures to respect a person's autonomy, ranging from manipulative underdisclosure of pertinent information to nonrecognition of a refusal of medical interventions. For example, in the debate over whether autonomous, informed patients have the right to refuse medical interventions, the principle of respect for autonomy suggests that an autonomous decision to refuse interventions must be respected. Although it was not until the late 1970s that serious attention was given to the rights of patients to refuse, this is no reason for thinking that respect for autonomy as now understood is a newly added principle in our moral perspective. It simply means that the implications of this principle were not widely appreciated until recently[15].

Controversial problems with the principle of respect for autonomy, as with all moral principles, arise when we must interpret its significance for particular contexts, determine precise limits on its application, and decide how to handle situations in which it conflicts with other moral principles. Many controversies involve questions about the conditions under which a person's right to autonomous expression demands actions by others, as well as questions about the restrictions society may rightfully place on choices by patients or subjects when these choices conflict with other values. If restriction of the patient's autonomy is in order, the justification will always rest on some competing moral principle such as beneficence or justice.

Nonmaleficence

Physicians have long avowed that they are obligated to avoid doing harm to their patients. Among the most quoted principles in the history of codes of health care ethics is the maxim *primum non nocere*: "Above all, do no harm." British physician Thomas Percival furnished the first developed modern account of health care ethics. He maintained that a principle of nonmaleficence fixes the physician's primary obligations and triumphs even over respect for the patient's autonomy in a circumstance of potential harm to patients:

> To a patient ... who makes inquiries which, if faithfully answered, might prove fatal to him, it would be a gross and unfeeling wrong to reveal the truth. His right to it is suspended, and even annihilated; because ... it would be deeply injurious to himself, to his family, and to the public. And he has the strongest claim, from the trust reposed in his

[15] Ibid, 77

> physician, as well as from the common principles of humanity, to be guarded against whatever would be detrimental to him.[16]

Some basic rules in the common morality are requirements to avoid causing a harm. They include rules such as do not kill; do not cause pain; do not disable; do not deprive of pleasure; do not cheat; and do not break promises.[7] Similar but more specific prohibitions are found across the literature of biomedical ethics, each grounded in the principle that intentionally or negligently caused harm is a fundamental moral wrong.

Numerous problems of nonmaleficence are found in health care ethics today, some involving blatant abuses of persons and others involving subtle and unresolved questions. Blatant examples of failures to act nonmaleficently are found in the use of physicians to classify political dissidents as mentally ill, thereafter treating them with harmful drugs and incarcerating them with insane and violent persons.[8] More subtle examples are found in the use of medications for the treatment of aggressive and destructive patients. These common treatment modalities are helpful to many patients, but they can be harmful to others.

A provocative question about nonmaleficence and physician ethics has been raised by Paul S. Appelbaum in an investigation of "the problem of doing harm" through testimony in criminal contexts and civil litigation— for example, by omitting information in the context of a trial, after which a more severe punishment is delivered to the person than likely would have been delivered. Appelbaum presents the generic problem as one of nonmaleficence:

> If physicians are committed to doing good and avoiding harm, how can they participate in legal proceedings from which harm may result? If, on the other hand, physicians in court abandon medicine's traditional ethical principles, how do they justify that deviation? And if the obligations to do good and avoid harm no longer govern physicians in the legal setting, what alternative principles come into play? ... Are physicians in general bound by the principles of beneficence and nonmaleficence?[17]

Beneficence

The physician who professes to "do no harm" is not usually interpreted as pledging never to cause harm, but rather to strive to create a positive balance of goods over inflicted harms. Those engaged in medical practice, research, and public health know that risks of harm

[16] Percival, Thomas; Percival, Edward. The Works, Literary, Moral and Medical: To which are Prefixed Memoirs of His Life and Writings and a Selection from His Literary Correspondence. J. Johnson Ed (2007). 66

[17] Appelbaum, P.S. (1997) A theory of ethics for forensic psychiatry. *Journal of the American Academy of Psychiatry and the Law*, 25, 233–47.

presented by interventions must often be weighed against possible benefits for patients, subjects, and the public. Here we see the importance of beneficence as a principle beyond the scope of nonmaleficence[18].

In ordinary English, the term *beneficence* connotes acts of mercy, kindness, charity, love, and humanity. In its most general meaning, it includes all forms of action intended to benefit other persons. In health care ethics beneficence commonly refers to an action done to benefit others, whereas benevolence refers to the character trait or virtue of being disposed to act for the benefit of others. The principle of beneficence refers to a moral obligation to act for the benefit of others. No demand is more important in taking care of patients: The welfare of patients is medicine's context and justification. Beneficence has long been treated as a foundational value—and sometimes as *the* foundational value[10]—in health care ethics[19].

The principle of beneficence requires us to help others further their important and legitimate interests, often by preventing or removing possible harms. This principle includes rules such as "maximize possible benefits and minimize possible harms" and "balance benefits against risks." Many duties in medicine, nursing, public health, and research are expressed in terms of a positive obligation to come to the assistance of those in need of treatment or in danger of injury. The harms to be prevented, removed, or minimized are the pain, suffering, and disability of injury and disease. The range of benefits that might be considered relevant is broad. It could even include helping patients find appropriate forms of financial assistance and helping them gain access to health care or research protocols. Sometimes the benefit is for the patient, at other times for society.

Some writers in health care ethics suggest that certain duties not to injure others are more compelling than duties to benefit them. They point out that we do not consider it justifiable to kill a dying patient in order to use the patient's organs to save two others, even though benefits would be maximized, all things considered. The obligation not to injure a patient by abandonment has been said to be stronger than the obligation to prevent injury to a patient who has been abandoned by another (under the assumption that both are moral duties). Despite the attractiveness of these notions that there is a hierarchical ordering rule, Childress and I reject such hierarchies on grounds that obligations of beneficence do, under many circumstances, outweigh those of nonmaleficence. A harm inflicted by not avoiding causing it may be negligible or trivial, whereas the harm that beneficence requires we prevent may be substantial. For example, saving a person's life by a blood transfusion clearly justifies the inflicted harm of venipuncture on the blood donor. One of the motivations for separating nonmaleficence from beneficence is that these principles themselves come into conflict. Since

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[18] Coughlin, SS (2008). How many principles for public health ethics. Open Public Health Journal. Jan 1: 1:8-16

[19] Fuchs, AE Autonomy, Slavery, and Mill's critique of Paternalism. Et*hical theory & moral practice*. 2001 Vol 4 (3) 231 -251.

the weights of the two principles can vary, there can be no mechanical decision rule asserting that one obligation must always outweigh the other[20].

Perhaps the major theoretical problem about beneficence is whether the principle generates general moral duties that are incumbent on everyone—not because of a professional role, but because morality itself makes a general demand of beneficence. Many analyses of beneficence in ethical theory (most notably utilitarianism[11]) seem to demand severe sacrifice and extreme generosity in the moral life—for example, giving a kidney for transplantation or donating bone marrow to a stranger. However, many moral philosophers have argued that such beneficent action is virtuous and a moral ideal, but not an obligation; therefore, there is no principle of beneficence of the sort proclaimed in the four-principles approach.

Justice

Every civilized society is a cooperative venture structured by moral, legal, and cultural principles of justice that define the terms of cooperation. A person in any such society has been treated justly if treated according to what is fair, due, or owed. For example, if equal political rights are due to all citizens, then justice is done when those rights are accorded. The more restricted notion of *distributive justice* refers to fair, equitable, and appropriate distribution in society. Usually this term refers to the distribution of primary social goods, such as economic goods and fundamental political rights, but burdens are also within its scope. Paying for forms of national health insurance is a distributed burden; medical-welfare checks and grants to do research are distributed benefits.

There is no single principle of justice in the four-principles approach. Somewhat like principles under the heading of beneficence, there are several principles, each requiring specification in particular contexts. But common to almost all theories of justice—and accepted in the four-principles approach—is the minimal (formal) principle that like cases should be treated alike, or, to use the language of equality, equals ought to be treated equally and unequals unequally. This elementary principle, or formal principle of justice, states no particular respects in which people ought to be treated. It merely asserts that whatever respects are relevant, if persons are equal in those respects, they should be treated alike. Thus, the formal principle of justice does not tell us how to determine equality or proportion in these matters, and it lacks substance as a specific guide to conduct.

Many controversies about justice arise over what should be considered the relevant characteristics for equal treatment. Principles that specify these relevant characteristics are often said to be “material” because they identify relevant properties for distribution. Childress and I take account of the fact that philosophers have developed diverse theories of justice that provide sometimes conflicting material principles. We try to show that there are some merits in egalitarian theories, libertarian theories, and utilitarian theories; and we defend a mixed use

[20] Gillon, R: (1985) ‘Beneficence: doing good for others’, *British Medical Journal,* 1985 291: 44-45

of principles in these theories. We regard these three theories of justice as appropriately capturing some of our traditional convictions about justice, and we think that they can all be tapped as resources that will help to produce a coherent conception of justice.

However, many issues of justice in health care ethics are not easily framed in the context of traditional principles and abstract moral theories.[21] For example, some basic issues in health care ethics in the last three decades center on special levels of protection and aid for vulnerable and disadvantaged parties in health care systems. These issues cut across clinical ethics, public health ethics, and research ethics. The four-principles approach tries to deal with several of these issues, without producing a grand theory for resolving all issues of justice. For example, we address issues in research ethics about whether research is permissible with groups who have been repeatedly used as research subjects, though the advantages of research are calculated to benefit all in society. We argue that since medical research is a social enterprise for the public good, it must be accomplished in a broadly inclusive and participatory way, and we try to specify the commitments of such generalizations. In this way, we incorporate principles of justice but do not produce a general theory of justice[22].

Implications of Beauchamp and Childress bioethical principles on the Midwife and Her Professional Obligations

The professional autonomy of the midwife, as the primary carer for most women and their newborn babies in this country, rests with the midwife maintaining credibility as the expert designated to give the best advice to women in regard to infant nutrition. Professional autonomy entails increased reliance on one's own judgment, and correspondingly the midwife is morally responsible for the consequences of her practice.

If the midwife believes that she is acting in the woman's best interests by enabling her to have a good night's sleep then she may consider her action [giving the baby artificial formulae] to be morally defensible. The benefit of a good night's sleep should not, however, have sufficient precedence over the known harmful consequences of a baby receiving artificial formulae. When the midwife gave a formula to the baby of a breastfeeding woman without her consent, then she was acting paternalistically. The midwife was also unprofessional because her judgement was marred by a lack of current knowledge. As Tom Beauchamp and James Childress put it:

> In professional relationships the argument is that a professional has superior training, knowledge and insight and is in an authoritative

[21] Gillon R. Medical ethics: four principles plus attention to scope. *BMJ*; 1994 309:184–188.

[22] Jennings B. Community in public health ethics. In: Ashcroft RE, Dawson A, Draper H, McMillan JR, editors. Principles of health care ethics. 2. New York: John Wiley & Sons; 2007. pp. 543–48

> position to determine what is in the patient's best interests. The professional is like a parent when dealing with dependent and often ignorant patients.[23]

In this case the midwife has mistakenly used her authority and consequently abused the dependent status of the woman to whom she has a duty of care.

When the midwife gives artificial formulae to the baby without the consent of the woman who has chosen to exclusively breastfeed her baby, the midwife not only harms the process of breastfeeding, but may cause short and long term harm to the newborn baby. Her knowledge is inadequate and may even border on culpable ignorance. The confusion between what is beneficial for the mother and what is beneficial to the baby is complicated by the midwife's lack of knowledge about the benefit of breastfeeding in relation to sleep, and patterns of breastfeeding in the newborn. McKenna demonstrates on film that babies left co-sleeping with their breastfeeding mother will actually knock on the breasts when seeking a feed and mimic the mother's movements during her sleep[24]. In l994 Jan Edwards the then President of the Board of the Australian Lactation Consultants Association [ALCA] in a personal communication re-affirmed that the practice of giving artificial formulae to babies of breastfeeding mothers, still continues.

Another instance where the paternalistic tendency of midwives is evident is when placing a baby in the nursery which limits easy access of the mother to her baby and consequently her ability to control what is fed to her baby. The failure of the woman to sleep through the night may be seen to reflect poorly on the midwife's perception of what a **good** midwife does in caring for the women in her care. The woman also may have unreal expectations about a good night's sleep. The need to prove that the woman had a good night's sleep may be a more powerful influence on the way the woman and the baby are managed, than whether the woman was assisted in her desire to establish breastfeeding.

It is true that the woman who has recently given birth to a baby is tired. However, for the newborn the urge to be fed (having recently been removed from a continuous supply of nutrients in utero) usually requires a range of frequency of feeds from one or even up to ten or more feeds (commonly referred to as **cluster feeds**) in the next twenty four hours, with a similar pattern for some weeks.

Most up to date midwives recognise this factor as being different from what was traditionally thought and accommodate the difference. Provided there is no maternal impediment, such as rare congenital lack of breast tissue, most healthy normal women can provide human milk for their newborn. As a leading textbook on the subject of breastfeeding states:

> It is advisable for numerous reasons to feed young infants whenever they indicate a need... In general young infants, especially newborns,

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[23] Beauchamp, T.L. & Childress, J.F. l989. *Principles of Biomedical Ethics.* New York: Oxford University Press. pp 212-213

[24] Harris, H. l994 President of ALCA Melbourne:

> have very irregular feeding intervals. They may feed at unevenly spaced intervals from 6 to 12, or as many as l8 times in a 24-hour period ...Mothers, [midwives, the general public and close relatives], may need reassurance that this early phase of very frequent feeding is likely to settle into more predictable routines as lactation is established.[25]

The quality of sleep of the newly delivered mother may also be improved by breastfeeding at night.

> ...There is a suggestion that dopamine receptors in the brain mediate sedation. ...this may account for the often reported and observed sleepiness that women experience when they breastfeed. [26]

The midwife is also lacking in knowledge about the effects of giving a bottle of artificial formulae, including its harmful effects on the baby as well as its interference with the process of breastfeeding. This interference with drainage, the *sine qua non* of successful breastfeeding sometimes results in painful blockage, engorgement, inflammation and abscesses of the breasts.

Conclusion

From the foregoing, there is need of to strengthen midwifery leadership and advocacy, provide regular ethics training, ensure legal protections for midwives in conflict settings, and develop clear institutional protocols for ethical consultation. These measures can enhance midwives capacity to resolve complex ethical challenges while safeguarding both patient and healthcare provider well-being. here is a need to establish support system such as functional ethical committee and ongoing ethics training. In addition, promoting a collaborative care model, and the development of a clear ethical are essential. Furthermore, revising institutional policies to empower midwives within clinical hierarchies may promote autonomy and accountability. Those interventions are critical to fostering ethically sound and respectful maternal care, particularly in resource-limited and culturally diverse settings.

[25] Royal College of Midwives [RCM] l991. *Successful Breastfeeding.* New York: Churchill Livingstone. p 33

[26] *ibid.*

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